

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040065

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5744

STATE FILE NUMBER

FILED NOV 7 1963

1. PLACE OF DEATH a. COUNTY. <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>71 Years</b>		Inside Limits <b>Yes</b> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1210 West 61st. St.</b>	
Inside Limits <b>Yes</b> No <input type="checkbox"/>		Reside on Farm <b>Yes</b> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Ernst Neuer</b>			4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-17-1874</b>	9. AGE (last birthday) <b>89 Yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat</b>		11. BIRTHPLACE (City and state or country) <b>Beerfelden, Germany</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Wilhelm Neuer</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Karolina K. Neuer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>Karolina K. Neuer</b>		Address <b>1210 West 61st Kansas City, Mo</b>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>myocarditis chronic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>2:20</b> a.m. <b>A.</b> Month, Day, Year <b>10-22-63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Missouri</b>
21. I attended the deceased from <b>Post 3 years</b> to <b>10-22-63</b> and last saw her/him alive on <b>10-21-63</b> Death occurred at <b>2:20 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <b>10/23/63</b>	
22a. SIGNATURE <b>[Signature]</b> (Degree or title)		22b. ADDRESS <b>M.D. 200 RIALTO BLDG, K.C. 6, MO.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-25-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>WAGNER FUNERAL HOME - K. C. MO.</b>		25. DATE RECD. BY LOCAL REG. <b>10-23-63</b>	26. REGISTRAR'S SIGNATURE <b>Bessie Smith</b>

USE BLACK INK

OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

T. S. Bourke

Dr. J. L. Baugh

Rinets

13445

99

012-3345

after 1:00 P.M.

260

0-50

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Alvin R. Haenschel

Licensed Embalmer No. 4159

P. O. Address Hannover City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.